

# Practice Guidelines for Civilian Providers

## *A Unique Perspective*



### Invisible Wounds of War

Summary and Recommendations for  
Addressing Psychological and Cognitive Injuries

From the Institute of Medicine (IOM) of the National Academies of Sciences, Engineering, and Medicine (NASEM), the National Academies Press (NAP), and the National Academy of Medicine (NAM).



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# The Need for Practice Guidelines

- DoD and VA efforts currently under way
  - *To address broad variability*
- AAS and SPRC Efforts
  - AMSR, reflects core competencies
  - RRSR
- Need to reflect multiple dimensions of the problem
  - In addition to assessment ←
  - Notion of brief treatment, clinical management
    - *Including what is demonstrated to work!*



# Historic Nature of Conflicts

- Duration of conflict
  - 11+ years
  - Two-front war
- Number of deployments
  - Heightened operational tempo
  - Limited relief even when “at home”
- Magnitude and severity of combat exposure
  - Repeated, daily exposure



# Combat Exhaustion Occurs Quickly

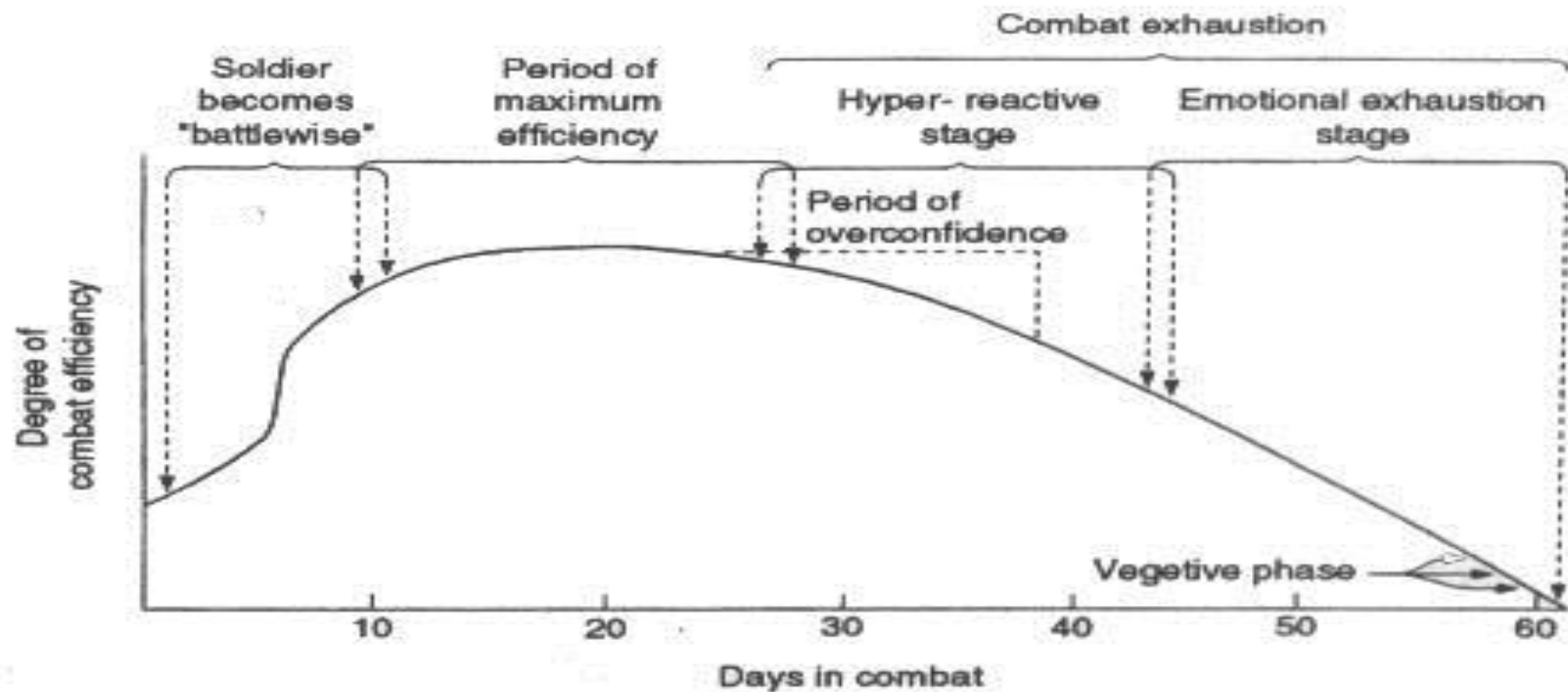
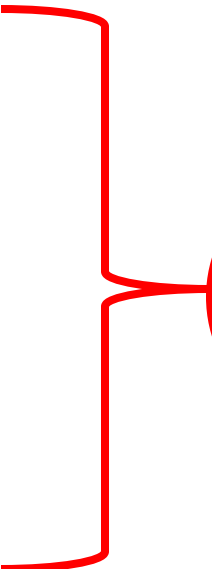


FIGURE 1 Effects of continuous combat.

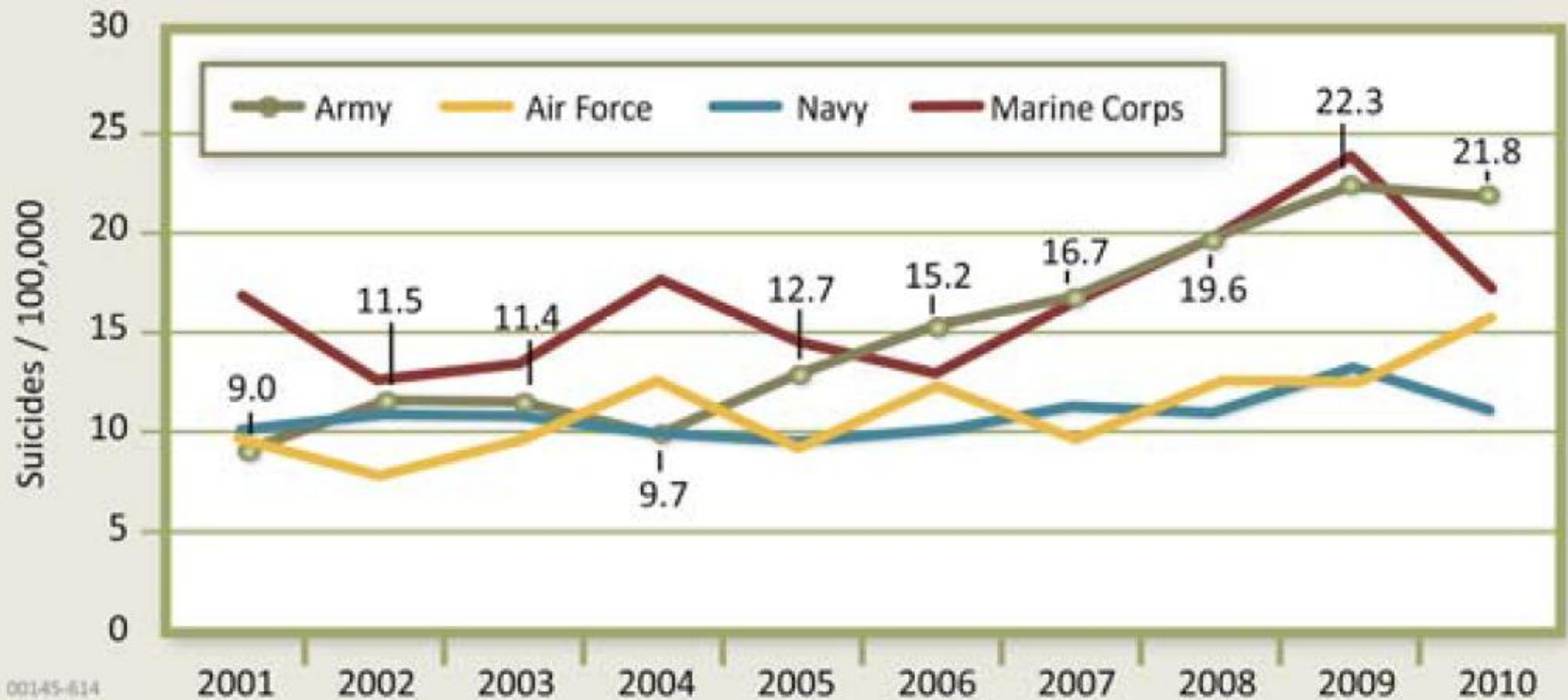
## Most Frequent Diagnoses in Sample

- Major depression
- Post-traumatic stress disorder
- Substance abuse
- Greater than 50% have marked comorbidity



Suicidality  
as Distinct  
Target

# Active duty suicide rates



## Understanding Cultural Context, Warrior Identity and Motivation to Die

- “I have now come to the conclusion that suicide is an absolutely selfish act. I am personally fed up with soldiers who are choosing to take their own lives so that others can clean up their mess”. “Be an adult, act like an adult, and deal with your real-life problems like the rest of us.”
- Major General Pittard

# U.S. Army Core Values

*and the problem of misinterpretation*

- **Loyalty**
- **Duty**
- **Respect**
- **Selfless Service**
- **Honor**
- **Integrity**

- **Personal courage**

- ***Face fear, danger or adversity (physical or moral).** Personal courage has long been associated with our Army. With physical courage, it is a matter of enduring physical duress and at times risking personal safety. Facing moral fear or adversity may be a long, slow process of continuing forward on the right path, especially if taking those actions is not popular with others. You can build your personal courage by daily standing up for and acting upon the things that you know are honorable.*

# Criteria for the Purple Heart

- “Indirect” injuries do not qualify
- PTSD and “battle fatigue” specifically excluded

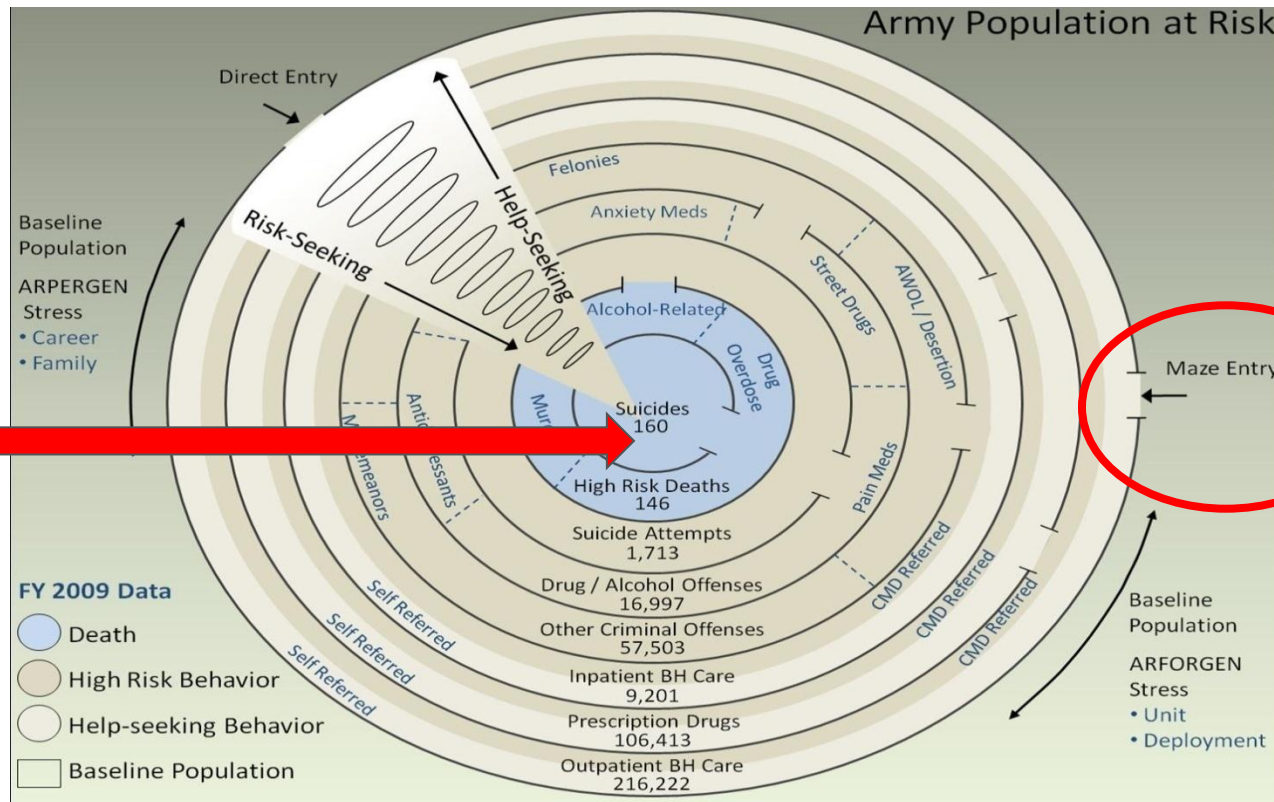


## It's not just the military: **Golden Gate Bridge**

- Two dozen+ deaths/year
- 1,300 since opening in 1937
- **Easy fix: netting**
- Approved 3 years ago
- Issue of funding delays implementation



# A Hopeful Message?



# The Persistence of Problems

## Student veterans

Severe depression	23.7%
Suicidal ideation	46%
Suicidal plan	20%
Suicide attempt	7.7%
Future attempt likely	3.8%

## General undergrad

Severe depression	28%
Serious suicidal ideation	6%
Suicide attempt	1.3%

6X



# Messaging and Hopelessness

- Consistency across all communications
- The importance of simplicity
  - Complex messages facilitate hopelessness
    - Session by session monitoring
  - Limited recall and memory secondary to symptom intensity & cognitive processing impairment
    - No-suicide contract example
    - Importance of “writing things down”



1-800-273-8255 **PRESS 1**

..... Confidential chat at [VeteransCrisisLine.net](http://VeteransCrisisLine.net) or text to **838255** .....

Veterans  
Crisis Line

Warning  
Signs

Suicide Prevention  
Resources

Brochures &  
Information

Campaign  
Materials

**IT'S YOUR CALL**

Confidential help for  
Veterans and their families

The Veterans Crisis Line is a toll-free, confidential resource that connects Veterans in crisis and their families and friends with qualified, caring VA responders.



Search the  
Mental Health Site

Search

FIND A VA FACILITY



## Elevated Risk in Soldiers and Elements of Intent

- Willingness to act (motivation to die)
  - *People talk about reasons for dying*
- Preparation to act (preparation and rehearsal behaviors)
  - *People prepare for their death*
    - *Will, letters, finances, research*
- **Capability to act**
  - *Builds over time with exposure*
  - *Ordinarily people engage in the behavior for some time prior to death*
    - *High Risk Behavior*
    - *Self-mutilation*
    - *Suicide Attempts*
- Barriers to act (reasons for living)
  - *People will discuss their ambivalence about death*
  - *Relationships critical*

# Capability to Act

- Daily exposure
  - Violence
  - Death
  - “Automaticity”
- Compounded by easy access
  - Weapons
  - Cultural context
  - Developmental History



# Typical Developmental History

- *Sure, as a kid my life sucked. My dad was a real jerk. Mom was just not there. He had been in the military. Reminded me on a daily basis what a loser I was, called me names, and used to beat me until I got big enough to kick his ass.*

# A Phased Approach to Management

- Recognizes the chronic nature of suicidal behavior
  - Recognizes limited skills/competency
  - Issue of foreseeability
- Competency based, i.e. skill mastery for progression
  - Independent of number of sessions attended
- Requires skill mastery for progression through treatment phases
- Will return to earlier phase if insufficient skill demonstrated in later treatment phase
- Relapse prevention is final treatment phase

## Phase I:

First  
Step

Crisis and self management, core distress  
tolerance skills

## Phase II:

Cognitive restructuring of suicidal belief system,  
problem solving, cognitive flexibility

## Phase III:

Relapse prevention

# Unique Elements of Management

- Suicidal behavior as distinct from diagnosis
- Focus on reducing suicide risk through skill development
- Self-management skills used to reduce reliance on hospitalization
- Focus on shared responsibility for treatment
- All aspects of treatment build hope
  - From treatment structure to targeted skills

# Primary Target: Reduce Stigma and Build Hope

- Reduce stigma associated with mental health problems
- Reduce stigma associated with help-seeking
  - Being in treatment and using crisis services
- Building Hope
  - Treatment structure
  - Model explaining suicidality
  - Symptom reduction
  - Identity change
    - Resolving hopelessness
  - Relationships that last

# What is Hope

- According to Oxford ED
  - *Noun: a feeling or expectation for something to happen*
  - *Verb: expecting something to happen, intend to do something*
- A critical player: Trust
  - *Reliance on the character, ability, strength or truth of someone or something*

# What are the Commonalities Across Treatments that Facilitate Hope?

- Remember:
  - Expectations are facilitated by
    - making the implicit explicit,
    - the complex simple,
    - the confusing understandable
    - the inaccessible available
  - Being flexible, all of these interventions are fluid not static
    - As the patient, treatment change so will expectations

# Management Structure and Hope

- Continuity in structure of each session
- Use of treatment journal
- Documentation every session
  - Summaries, significant “learning moments”
- Use of “cards”
  - Reasons for living, crisis management, coping

*What do we actually know  
works for suicide risk?*

## **60+ psychosocial clinical trials targeting suicidality**

- “Clinical trial” = study including both treatment and control (or comparison) condition
- Randomization not required
- 28 (53%) were cognitive-behavioral
- Only one RCT has utilized military personnel  
(Rudd et al., 1996)

# 5 Things that Save Lives

## 1. Easy to understand treatment model

- Identifying developmental history, early **skill development/deficiencies** related to current functioning
  - Susceptibility expressed through “triggering”
- Three targets
  - Thoughts (and core beliefs)
    - Motivation for dying
  - Feelings (physiological/emotional)
  - Behavior (increasing adaptive)

## Skill sets that don't work in adulthood

- Avoidance
  - Cognitive
  - Behavioral
  - Emotional



Linked to Development

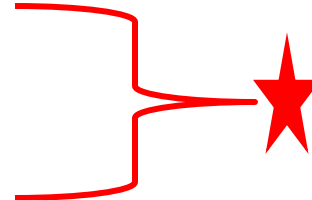
- Passive-aggressive behavior
- Submissive behavior
- Aggression

## 2. A focus on treatment compliance

- Specific interventions and techniques to target poor adherence and motivation
  - Usually a function of poor skills
  - Phone calls and texts for encouragement
- Clear directions about *what to do* if non-adherence emerges

### 3. Focus on skills-building

- Identification of skills deficits with opportunity for skills building and practice
  - Emotion Regulation
  - Interpersonal
- Clear understanding of “what is wrong” and “what to do about it”
- Separate from identity



# Emotion regulation strategies

- Relaxation training
- Mindfulness training
- Reasons for living list
- Survival kit
  - Including Reasons for Living
- Sleep hygiene / stimulus control
- Recognize critical role of shame/guilt/grief

# Confusing Guilt and Grief

- Recognizing the similarities between the two
  - Cognitive, emotional, behavioral
- Conceptualization of grief from combat
  - Loss of close relationships

## 4. Taking Personal responsibility

- Emphasis on patient self-reliance and self-management
  - *Commitment to Treatment Statement*
  - *Crisis management/safety plan*
- Patients assume high level of responsibility for their care, including crisis management

# Elements of a Good Agreement?

- Defined as a commitment to
  - Living
  - Treatment and care
- Incorporates a crisis management or response plan
- Specifically identifies responsibilities
  - Patient
  - Clinician

## 5. Easy access to treatment and crisis services

- Clear plan of action for emergencies
  - Crisis management/safety plan
- Dedication of time to practicing skills necessary to identify true crisis, using crisis plan, and using external support services judiciously

# Effective Management of Crises Means Facilitating Hope in Treatment

- Define *crisis*
- Make it accessible!
- Identify warning signs! (for family as well)
- Provide a simple model of suicidality---Identify trigger (s) and associated thoughts, feelings, behaviors.
- **Specific goal is to reduce escalation of suicidal crisis and reduce manifest intent (increase hope)**
- **Moves from self-management to external intervention—improve self-efficacy.**
- If not successful, access emergency care and assistance in manner that facilitates skill development (always understand the cost and consequence)

# Essential Elements of a CRP

- Self-management prior to external intervention
- Integration of external support
  - Identification of healthy support resources
  - Role play how to access support
  - Practice
- Means restriction
  - Use of receipt

# Practice, Practice, Practice

- *When I find myself making plans to suicide, I agree to do the following:*
  - 1. Use my survival kit.
  - 2. Review my treatment journal
  - 3. Do things that help me feel better for about 30 minutes, including taking a bath, listening to music, and going for a walk
  - 4. If the thoughts continue, get specific, and I find myself preparing to do something, I call the emergency number XXX-XXXX
  - 5. If I'm still feeling suicidal and don't feel like I can control my behavior, I go to the emergency room

# Creating a Survival Kit

- The notion of reciprocal inhibition
- Include items that generate productive, hopeful thoughts and feelings
- Always review items individually
- Practice use of Survival Kit
  - Review each item
  - Ask patient to describe item, “tell a little about it”
  - What are they thinking?
  - What are they feeling?
  - More hopeful?

# Clinical Practice Guidelines

- Simple
- Straightforward
- Essential, proven elements
- Emphasis on cultural awareness and sensitivity
  - Related to compliance, adherence